DISTRICT OF COLUMBIA EMPLOYEES BENEFITS ENROLLMENT REGISTRATION FORM

☐ 2016 New Enrollment ☐ Change

1 Employee Information: (All information is required)

Last Name:	**First Name:**	**Middle Initial:**
Home Address:		
City:	**State:** **Zip:**	**Employee ID Number:**
Social Security Number:	**Gender:**	**Date of Birth (MM/DD/YYYY):**
Home Phone:	**Work Phone:**	**Email Address:**
Agency:	**Position Title:**	**Work Location:**

2 Health Insurance: DCEHB provides coverage for full-time and part time benefits eligible employees. Your payroll deductions will be deducted on a pre-tax basis. If enrolling a Domestic Partner or Domestic Partner and family, your benefits will be deducted after-tax. Employees pay a share of the cost for health benefits coverage. An employee or family member cannot be covered under more than one DCEHB enrollment.

Coverage Tier:		**Health Plan:**	
☐ Employee Only	☐ I Waive Health Coverage	☐ Aetna - CDHP	☐ Kaiser Permanente- HMO
☐ Employee + 1	☐ Check here if you are enrolling a Domestic Partner	☐ Aetna - HMO	☐ United Healthcare Nationwide
☐ Employee & Family		☐ Aetna - PPO	

3 Dental & Optical Insurance (Non-Union Employees ONLY): DCEHB provides coverage for full-time and part time benefits eligible employees. An employee or family member cannot be covered under more than one DCEHB enrollment. **NOTE: Union employees must connect with their union to ensure coverage. This form will not guarantee coverage for union employees.**

Coverage Tier:	**Optical Plan:**	**Dental Plan:**
☐ Employee Only	☐ Quality Plan Administrators	☐ Cigna DHMO
☐ Employee & Family	☐ I Waive Optical Coverage	☐ Cigna PPO
☐ Check here if you are enrolling a Domestic Partner		☐ I Waive Dental Coverage

4 Dependents: List all dependents (not including yourself) to be covered by this enrollment. Coverage is available to dependent children up to age 26.
* 1=Spouse 2=Son 3=Daughter 4=Domestic Partner (Domestic Partners must meet the requirements of 29 DCMR 8001.1)

Name	Relationship*	Gender	Date of Birth	SSN	Full Time College Student?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

5 Flexible Spending Accounts: DCEHB provides coverage for full-time and part- time benefits eligible employees. This program is administered by Pay Flex.

☐I wish to participate in the Healthcare Account by electing $ _____**(Minimum $100.00 - Maximum $2,500.00 per calendar year)**	☐I wish to participate in the Dependent Care Account by electing $_____ (**Minimum $100.00 - Maximum $5,000.00 per calendar year**)
☐I wish to participate in the Commuter Pre-Tax Transit Plan by electing $_____ **(Maximum $130.00 per month/$1,560.00 per calendar year)**	☐I wish to participate in the Commuter Pre-Tax Parking Plan by electing $_____**(Maximum $250.00 per month/$3,000.00 per calendar year)**

6 Short Term Disability ☐ Voluntary ST Disability

7 Long Term Disability ☐ Voluntary LT Disability

8 Life Insurance: DCEHB provides coverage for full-time and part- time benefits eligible employees. Employees pay a share of the cost for basic coverage and the full cost for optional coverage.

Waiver of All Coverage	**Basic Life**	**Option A Standard**	**Option B - Additional**	**Option C – Family Coverage**
☐ I want no life insurance coverage at all. I understand that my decision to waiver coverage now will affect my ability to enroll at a later date.	☐ I want the Basic Life Insurance. **NOTE:** If you do not elect Basic Life, you may not elect Option A, B or C.	☐ I want the Standard $10,000 optional insurance.	☐ I want the Additional optional insurance in the multiple of my annual basic pay I indicate below by marking "X" in the appropriate box. ☐ 1 times my pay ☐ 4 times my pay ☐ 2 times my pay ☐ 5 times my pay ☐ 3 times my pay	☐ I want the Family optional insurance. In the event of their death I would receive: ☐ 10K- Dependent ☐ 10K- Dependent - 10K Spouse ☐ 10K- Dependent - 25K -Spouse ☐ 10K- Dependent - 50K-Spouse

In making this election I understand that: I cannot change or revoke this compensation reduction agreement at anytime during the year for which this election is made, unless I have a change in family status (including marriage, divorce, death of a spouse or child, employment or termination of employment of spouse, birth of a child, adoption of a child). Additionally, I understand that I have 31 days from my hire date to submit my initial enrollment form and 31 to 60 days from the date of any qualifying event to make these elections.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if the applicant provided false information materially related to a claim.

Employee Signature: ➡		**Date:**	
DC Public Schools			
Agency	***Signature of Authorized Agency Official***	***Date Processed***	***Effective Date***